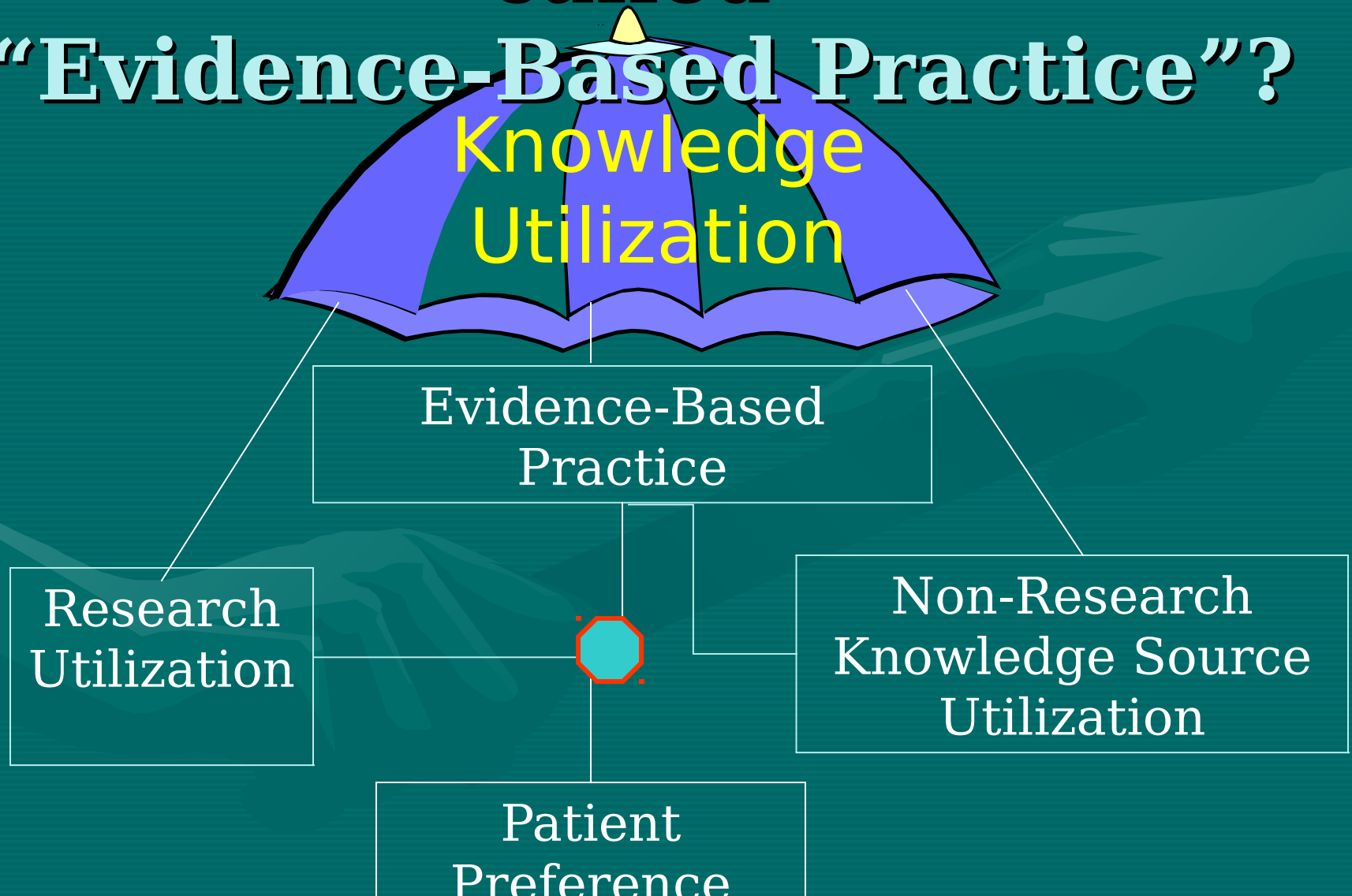


Easier Said Than Done



Evidence-Based Performance Improvement

Just what is this thing called “Evidence-Based Practice”?



Why is it so confusing?

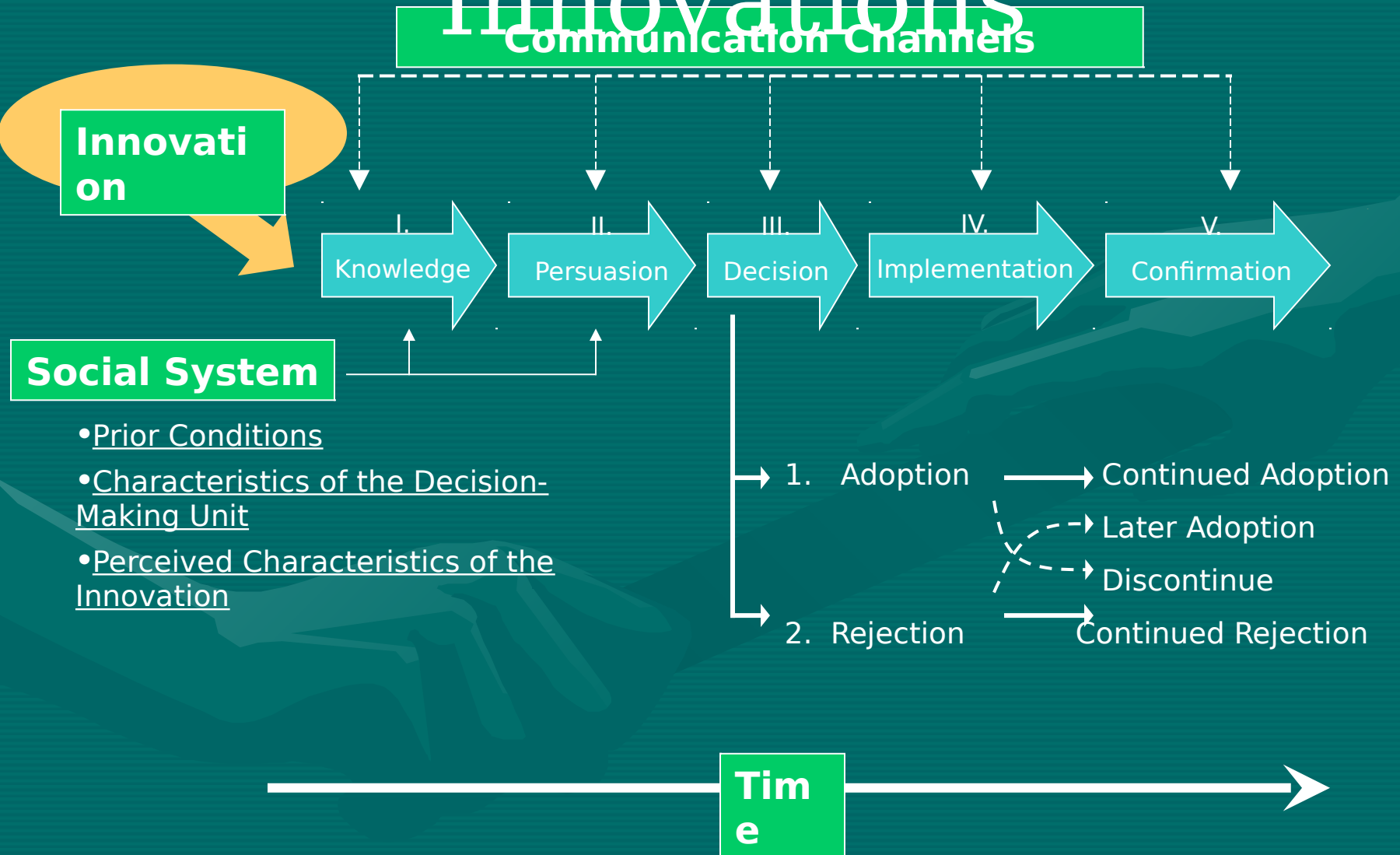
- Many terms used, sometimes interchangeably
- Vague definition of terms
- Disciplines apply evidence differently
- Evidence IS different



Evidence-based practice is:

"a total process beginning with knowing what clinical questions to ask, how to find the best practice, and how to critically appraise the evidence for validity and applicability to the particular care situation. The best evidence then must be applied by a clinician with expertise in considering the patient's unique values and needs. The final aspect of the process is evaluation of the effectiveness of care and the continual improvement of the process" (DePalma, 2000).

Rogers' Diffusion of Innovations



Independent Variables Variable

Dependent

Individual (Leader) Characteristics

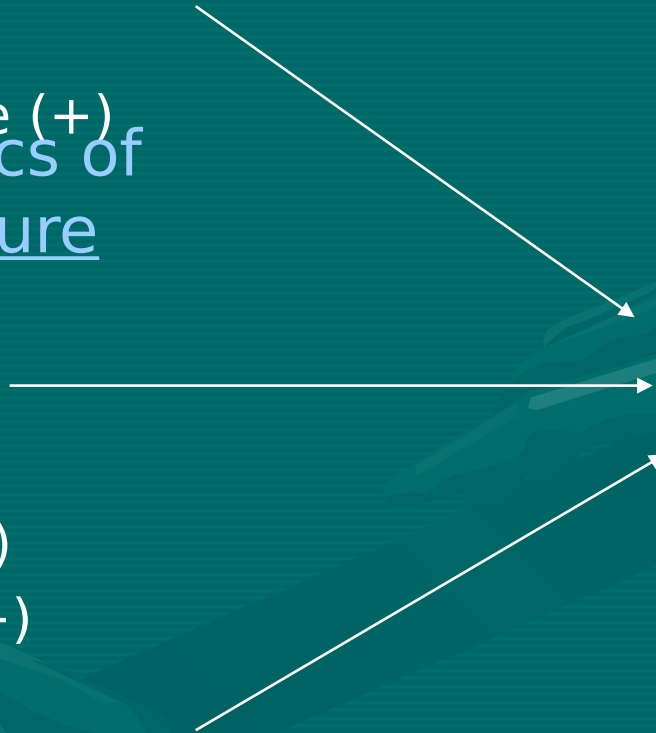
1. Attitude toward change (+) Internal Characteristics of Organizational Structure

1. Centralization (-)
2. Complexity (+)
3. Formalization (-)
4. Interconnectedness (+)
5. Organizational Slack (+)
6. Size (+)

External Characteristics of the Organization

1. System Openness (+)

Organizational Innovativeness



**Clinician Experience
+ Patient Preferences
+ Scientific
Findings
= Evidence-Based
Guidelines**



Asking the Questions

- Problem Focused
 - Is current practice adequate to address concerns or problems?
- Knowledge Focused
 - New information out regarding a practice area
- Knowledge AND Problem Focused



Forming a Team

- Who would you want on your team?

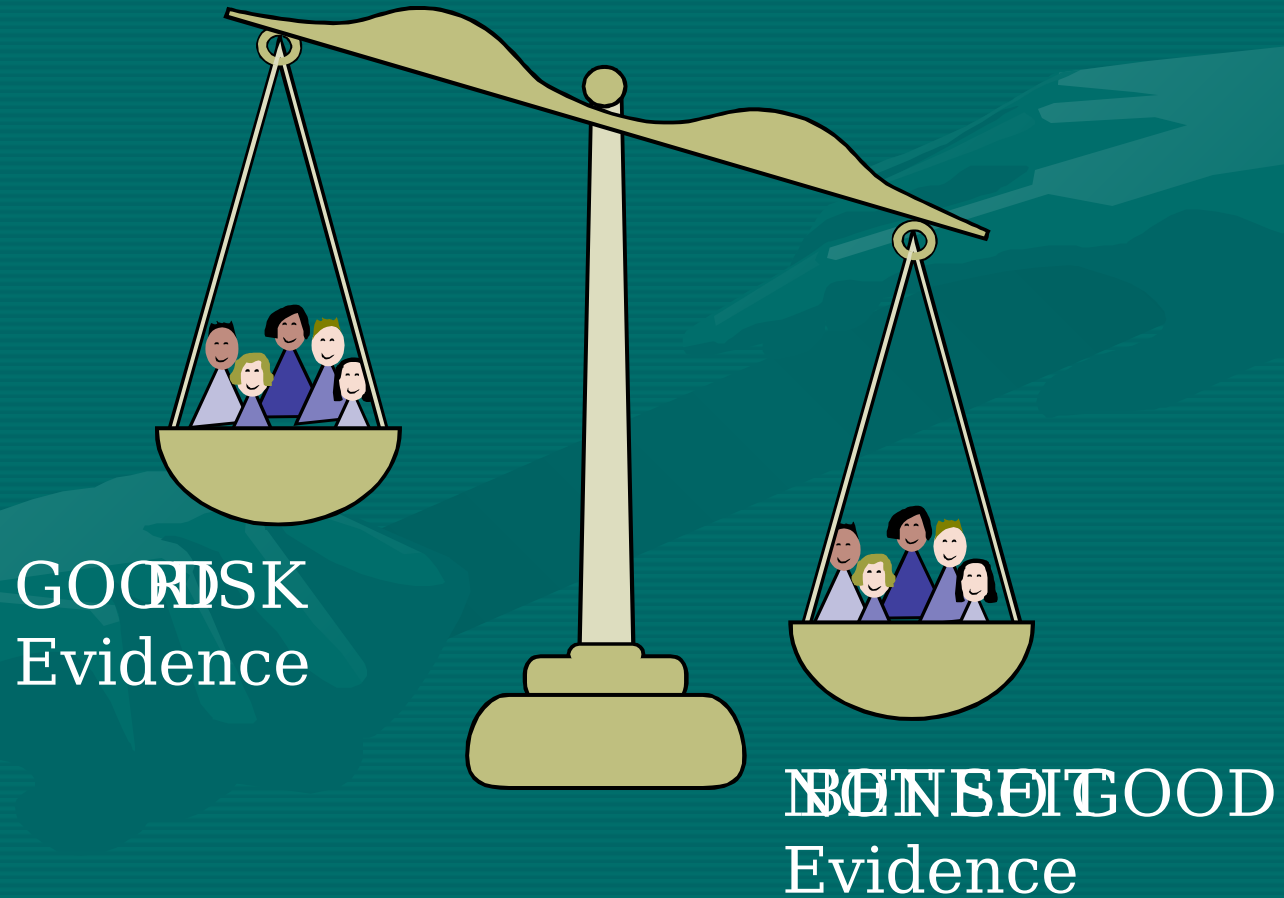


Finding the Best Practice



Appraising the Evidence

★ Not all evidence is created equally



Types of Research: Evidence Hierarchies

Agency for Healthcare Research and Quality (AHRQ)

Level I	Meta-Analysis (Combination of data from many studies)
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Level II	Experimental Designs (Randomized Control Trials)
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Level III	Well designed Quasi Experimental Designs (Not randomized or no control group)
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Level IV	Well designed Non-Experimental Designs (Descriptive-can include qualitative)
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Level V	Case reports/clinical expertise
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Level I	Meta-Analysis (Combination of data from many studies)
---------	---

Level II	Individual Experimental Design (Randomized Control Trials)
----------	--

Level III	Quasi Experimental Designs (Not randomized or no control group)
-----------	---

Level IV	Non-Experimental Designs (Descriptive-can include qualitative)
----------	--

Strength of Evidence

United States Preventive Services Task Force (USPSTF) Grading

A

Strongly recommended; Good evidence

B

Recommended; At least fair evidence

C

No recommendation; Balance of benefits and harms too close to justify a recommendation

D

Recommend against; Fair evidence is ineffective or harm outweighs the benefit

I

Insufficient evidence; Evidence is lacking or of poor quality, benefit and harms cannot be determined

Change vs. Further



"C'mon, c'mon—it's either one or the other."

Applying the Evidence

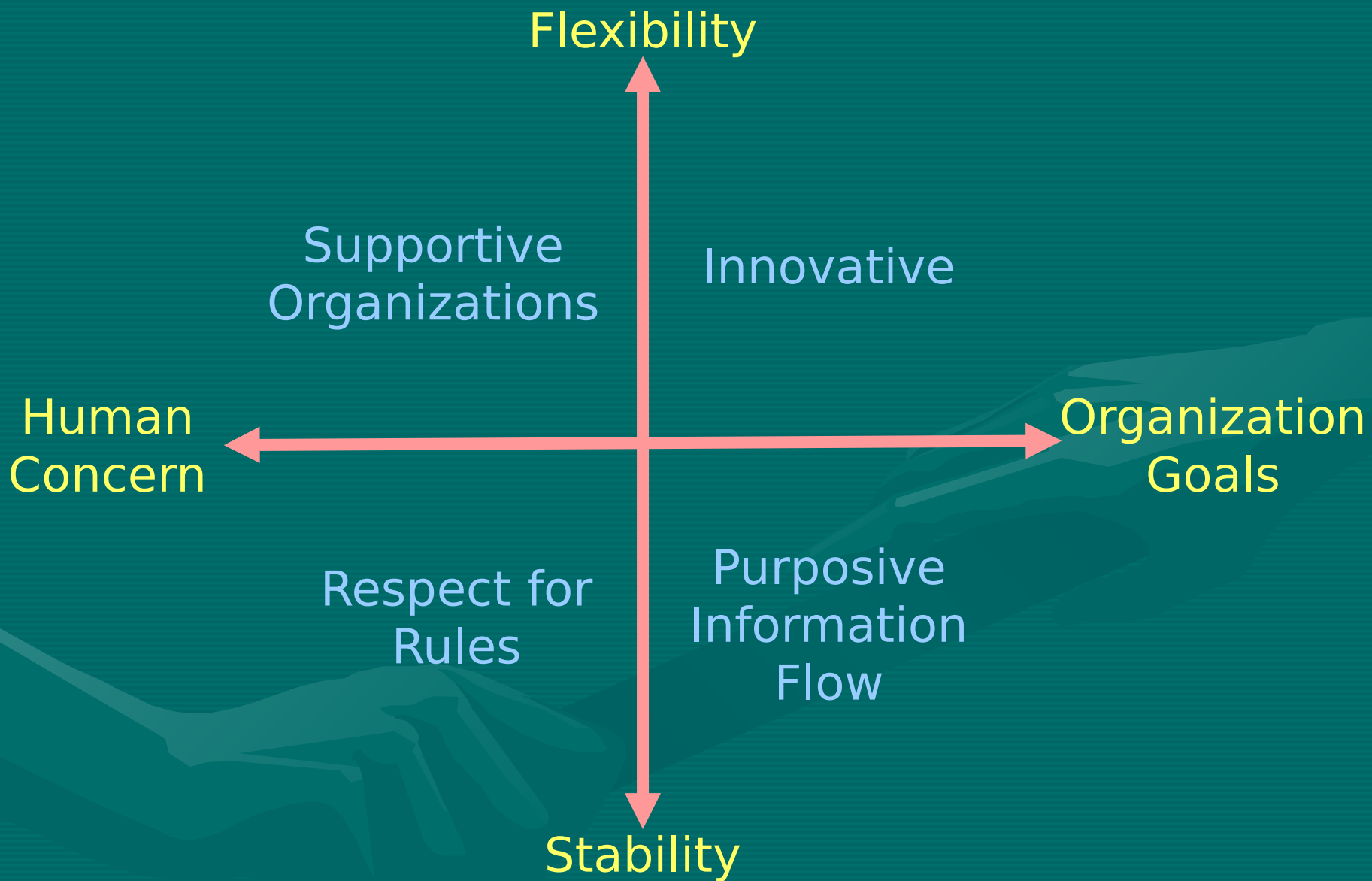


Barriers

- Time (Individual and Organizational)
- Access to Evidence
- Attitudes toward Research
- Belief Suspension and Change
- Support

Facilitators

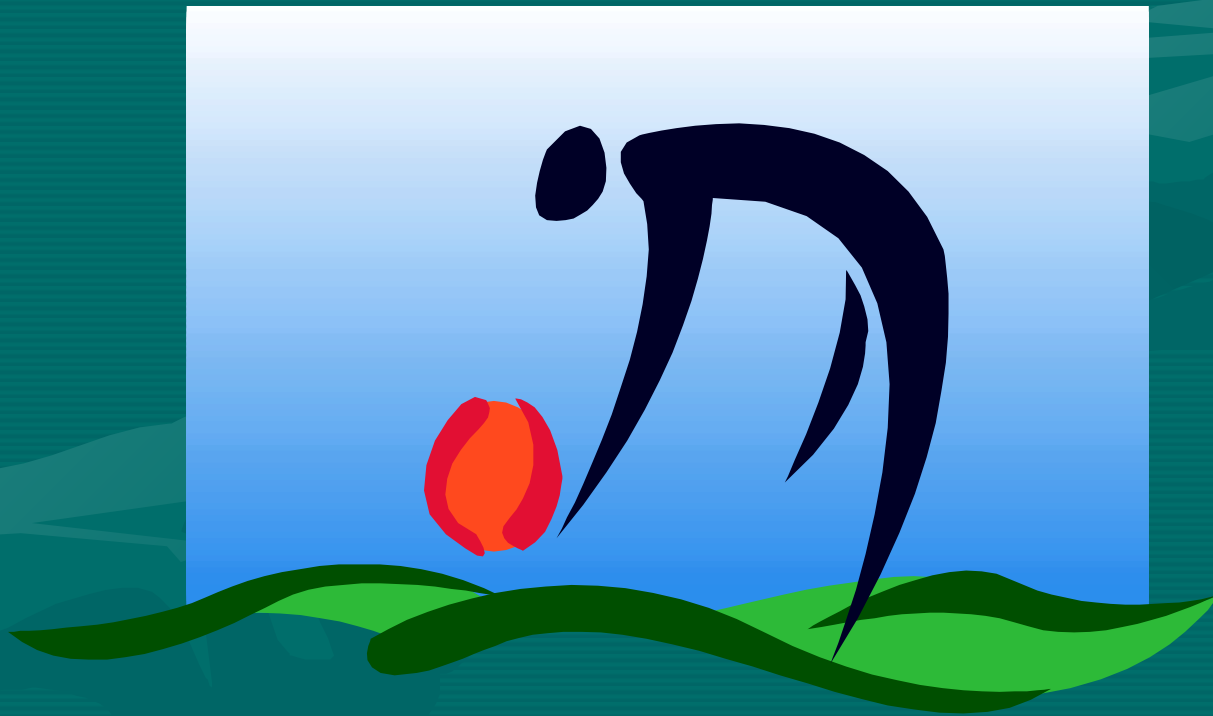
- Time (Individual and Organizational)
- Access to Evidence
- Attitudes toward Research
- Belief Suspension and Change
- Support
- Champion



Mylle's Representation of Organizational Climate

Instituting the Change

- Start Small—Pilot the change before adopting organization-wide



Continuous Evaluation

- Measure the outcomes
- Measure the Process Variables



Don't forget to disseminate

- Share your Success – or – Failure



Keep it Simple



**We need to
change the
paradigm.....**





from
Research vs Practice

to
Research Equal



Questions???



If you would like more information on Evidence-Based Practice or a copy of these slides, please e-mail me at deborah.kenny@na.amedd.army.mil or call at (202) 782-7025